TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SAMUEL ALIANELL MD PA

Respondent Name
FEDERAL INSURANCE COMPANY

MFDR Tracking Number
M4-17-3820-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
August 24, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The charges referenced herein were filed with the Carrier and denied for 'payment adjusted because the payer deems the information submitted does not support this many/frequency of services'. We have requested documentation to support the charges and requested reconsideration from the carrier and they have maintained the denial rationale. We believe this claim has been denied arbitrarily and respectfully request dispute resolution in this matter."

Amount in Dispute: $1,021.70

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on August 31, 2017. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF DISPUTED SERVICE(S)

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
February 6, 2017	G0482	$1,021.70	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 151 – Payment adjusted because the payer deems the information submitted does not support his many/frequency of services.

Issue(s)

1. Are the insurance carrier's denial reasons supported?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed HCPCS Code G0482 rendered on February 6, 2017. The insurance carrier denied the disputed service with denial rationale "Payment adjusted because the payer deems the information submitted does not support this many/frequency of services."

   The service in dispute, HCPCS Code G0482 is for clinical laboratory services subject to 28 Texas Administrative Code §134.203 (b) which states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   HCPCS Code G0482 is defined as "Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 15-21 drug class(es), including metabolite(s) if performed."

   Review of the submitted documentation does not document the 15-21 drug class (es). As a result, the Division finds that the insurance carrier's denial reason is supported. The requestor is therefore not entitled to reimbursement for the disputed HCPCs Code G0482 rendered on February 6, 2017.

2. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for the disputed service. Therefore $0.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		December 15, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.